



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

DOUGLAS M STAUCH, MD  
PO BOX 741865  
DALLAS, TEXAS 75374

#### **Respondent Name**

AMERICAN ZURICH INSURANCE CO

#### **Carrier's Austin Representative Box**

Box Number 19

#### **MFDR Tracking Number**

M4-11-4619-01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "CARRIER IS REQUIRED TO PAY DD EXAMS"

**Amount in Dispute:** \$1,150.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** A copy of dispute was placed in carrier rep box on August 11, 2011 with no response to MFDR.

**Response Submitted by:** NA

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 14, 2011	99456-WP-W5 and 99456-RE-W8	\$1,150.00	\$1,150.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:  
Explanation of Benefits (EOB)-NA

### Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement?

### Findings

1. There are no EOBs, response to request for reconsideration, nor response to MFDR regarding denial of disputed services. The Division will proceed with this review per applicable fee guidelines.
2. The provider billed the amount of \$650.00 for CPT code 99456-W5-WP for DD Examination for MMI/IR. Review of the documentation supports that MMI was assigned and one body area was rated. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is \$350.00. To determine reimbursement for an IR, the method of calculating IR and the number of body areas/conditions is reviewed. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I)(a), the MAR for a 1<sup>st</sup> musculoskeletal area IR using Range of Motion (ROM) on left shoulder (upper extremity) is \$300.00. The combined MAR for the MMI/IR exam is \$650.00. The DD also billed \$700.00 for CPT code 99456-RE-W8 for a Return to Work (RTW) examination. Per 28 Texas Administrative Code §134.204(j)(2)(A) & (k), the MAR for the 1<sup>st</sup> RTW and/or Evaluation of Medical Care (EMC) examinations is \$500.00. Review of documentation supports that the Division ordered the examinations, therefore the reimbursement of \$650.00 for the MMI/IR and \$500.00 for the RTW is due to requestor for a total of \$1,150.00.

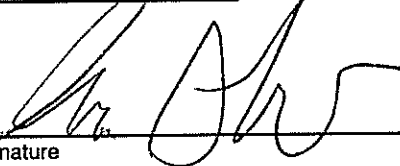
### Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$1,150.00.

### **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1,150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### Authorized Signature



\_\_\_\_\_  
Gregory Fournerat  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
November 3, 2011  
Date

### **YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**